MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07679

7675 **CERTIFICATE OF DEATH** Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Indian Head
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 12 Blair Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head X
STREET ADDRESS (If rural, give location) 12 Blair Road 1

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) Aquilla (Last) Butler

4. DATE OF DEATH: (Month) August (Day) 19 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 11-4-69

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Butler

14. MOTHER'S MAIDEN NAME: Elizabeth Hartley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: James W. Butler, Ind. Head. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1 **Immediate cause** (a) Coronary Occlusion — Interval Between Onset and Death: Immed

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO (b) Chronic Myocarditis — 3 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) M. OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 12, 1955 to Aug 19, 1955, that I last saw the deceased alive on Aug 16, 1955, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Grant G Susan M.D. Indian Head. Md 8-19-55

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 8-22-55

NAME OF CEMETERY OR CREMATORY St. Joseph's Catholic

LOCATION (City, town, or county) (State) Pomfret Md

DATE REC'D BY LOCAL REG. 8/22/55

REGISTRAR'S SIGNATURE Julia H Bailey

24. FUNERAL DIRECTOR Hoult & Ryon ADDRESS Waldorf, Md.

7676 MARYLAND STATE DEPARTMENT OF HEALTH 07680

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Items 18&21 Film G186 9-13-55 ams

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY Charles; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Malcolm; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Charles; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf; STREET ADDRESS (If rural, give location) X

3. NAME OF DECEASED (Type or Print): (First) MORRIS (Middle) ARTHUR (Last) CHAPMAN

4. DATE OF DEATH: (Month) 8 (Day) 28 (Year) 55

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 1934

9. AGE last birthday: 21 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Anna Yates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-30-0975

17. INFORMANT AND ADDRESS William Wood 3901 Conn. Ave. N.W., Wash 8, D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

8/2 X Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 8-28-55

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Fractured Skull — 8-28-55

(c) Hit by auto — 8-28-55

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highway | (CITY OR TOWN) Malcolm (COUNTY) Md. (STATE)

TIME OF INJURY (Month) 8 (Day) 28 (Year) 55 (Hour) 4PM | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? Hit by auto

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐*

SIGNATURE C. Edelen (Degree or title) md | ADDRESS La Plata Md | DATE SIGNED 8-28-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 8-31-55 | NAME OF CEMETERY OR CREMATORY St. Peters | LOCATION (City, town, or county) Waldorf, (State) Md.

DATE RECD BY LOCAL REG. 9/1/55 | REGISTRAR'S SIGNATURE Julia H Casey

24. FUNERAL DIRECTOR Huntt & Ryon, ADDRESS Waldorf, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07681

CERTIFICATE OF DEATH

7677

Reg. Dist. No. 106

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Bryans Road — LENGTH OF STAY (in this place): 10 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: (P.O. Address) Box 118 Indian Head

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bryans Road — X
STREET ADDRESS (If rural, give location): /

3. NAME OF DECEASED: (Type or Print) (First) Rose (Middle) Virginia (Last) Dotson

4. DATE OF DEATH: (Month) August (Day) 4 (Year) 19 55

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday: yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	Colored	Single	Sept 28, 1954.		10			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant	—	Bryans Road, Md	U.S.

13. FATHER'S NAME: Archie W Dotson

14. MOTHER'S MAIDEN NAME: Catherine Branson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
NO		—	Beverly Dotson, Box 118 Indian Head

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

571.0

Immediate cause (a) Enteritis Infections — DUE TO — Interval between onset and death: 6 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/1, 19 55, to 8/4, 19 55, that I last saw the deceased alive on 8/1, 19 55, and that death occurred at 9 A.M., from the causes and on the date stated above.

SIGNATURE Frank G. Dusan — (DEGREE OR TITLE) M.D — ADDRESS Indian Head, Md — DATE SIGNED 8-4-55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-4-55	Metropolitan	Bryans Road Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-5-55	M. E. Cassome	Penny & Cofer	Mason Springs Md.

4094407404

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07682

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

7678

Item 9, Film G185 8-29-55 et

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Charles — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rock Point
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Chas.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rock Point X
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): James Wilbert EDELEN

4. DATE OF DEATH: (Month) Aug 18, (Day) (Year) 1955

5. SEX: M

6. COLOR OR RACE: Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Jan 29 1929

9. AGE last birthday: 26 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Lumberman

11. BIRTHPLACE (State or foreign country): Charles Co Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arthur Edelen

14. MOTHER'S MAIDEN NAME: Catherine Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.:

17. INFORMANT AND ADDRESS: Catherine J. Dorsey Waysides Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 8-18-55

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?:

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE E. Edelen (Degree or title) MD — **ADDRESS** La Plata Md — **DATE SIGNED** 8-18-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — **DATE THEREOF**: Aug 20 55 — **NAME OF CEMETERY OR CREMATORY**: Holy Ghost — **LOCATION (City, town, or county) (State)**: Issue Md

DATE RECD BY LOCAL REG.: 8/19/55 — **REGISTRAR'S SIGNATURE**: Julia H Posey

24. FUNERAL DIRECTOR — **ADDRESS**: Burkart Funeral Home Inc La Plata Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07683

CERTIFICATE OF DEATH

Reg. Dist. No. 106

7679

1. PLACE OF DEATH:

COUNTY Charles MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head Md

LENGTH OF STAY (in this place) one Day

HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Charles

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head Md

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) (Infant) (Middle) (Last) Estep

4. DATE OF DEATH: (Month) (Day) (Year) 8-17-55 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F.	N.	Single	8-17-55	8-17-55 yrs.				30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? One Day

13. FATHER'S NAME: William Smith

14. MOTHER'S MAIDEN NAME: Velma Agnes Estep

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: (Grandmother) Florine Estep

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

774X

Immediate cause (a) Prematurity (Five Month Gestation) DUE TO — Interval between onset and death: 30-Minutes.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-17-55, 19 8-17-55, 19....., that I last saw the deceased alive on 8-17-55, 19....., and that death occurred at 12:05 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED 8-17-55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/18/55	Mt. Hope	Iron Sides Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/17/55	Odley Price	Tom Smith (Father)	Mapenoy, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

10851812-01

07684

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

7680

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waysside
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
STREET ADDRESS (If rural, give location) Waysside

3. NAME OF DECEASED (Type or Print): (First) EMMA (Middle) (Last) HEMSLEY

4. DATE OF DEATH: (Month) Aug (Day) 4 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 15, 1886

9. AGE last birthday: 69 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ZAK FORD

14. MOTHER'S MAIDEN NAME: ELIZA CALBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Glenda Washington nearburg md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 154X Carcinoma of Rectum — Interval Between Onset and Death: 8 Months

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 Dec, 19 54, to 5 Aug, 19 55, that I last saw the deceased alive on 6 Dec, 19 54, and that death occurred at 9-30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frederick M Johnson MD. ADDRESS La Plata, Md. DATE SIGNED 5 Aug 55

23. BURIAL, CREMATION / REMOVAL (Specify): Burial
DATE THEREOF: Aug 8, 1955
NAME OF CEMETERY OR CREMATORY: Shiloh
LOCATION (City, town, or county) (State): Waysside Md

DATE REC'D BY LOCAL REG. 8/5/55
REGISTRAR'S SIGNATURE: Julia H. Casey

24. FUNERAL DIRECTOR: Hunter & Ryon ADDRESS: Waldorf, Md

7681

07685 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 100

1. PLACE OF DEATH:
COUNTY: CHARLES COUNTY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL-BRYANTOWN
LENGTH OF STAY (in this place): 9 HRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: NONE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE — COUNTY: 47X-3
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: WASHINGTON, D.C.
STREET ADDRESS (If rural, give location): 2615 - 22nd ST. N.E.

3. NAME OF DECEASED: (Type or Print) (First) CLAYTON (Middle) IGNATIUS (Last) HIGDON

4. DATE OF DEATH (Month) AUG. (Day) 1st (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: FEB 5/1894

9. AGE last birthday: 61 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): INSURANCE AGENT

10b. KIND OF BUSINESS OR INDUSTRY: PRUD INS CO

11. BIRTHPLACE (State or foreign country): CHARLES COUNTY, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LEWIS AMBROSE HIGDON

14. MOTHER'S MAIDEN NAME: MARGARET SUSANNA THOMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES. (If Yes, give war or dates of service) W.W.I.

16. SOCIAL SECURITY NO.: 577-07-2248

17. INFORMANT & ADDRESS: MRS. MARGARET P. HIGDON - 2615-22nd ST. NE WASH. D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1
Immediate cause (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 48 HOURS
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) ANGINA PECTORIS — 14 YEARS
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: John H. Geoffrin
CHIEF MEDICAL EXAMINER / DEPUTY MEDICAL EXAMINER / ASSISTANT MEDICAL EXAM. M. D.
DATE SIGNED: 8/1/55

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): BURIAL
DATE THEREOF: 8/4/55
NAME OF CEMETERY OR CREMATORY: FT LINCOLN
LOCATION (City, town, or county) (State): COLMAR MANOR, MD

DATE REC'D BY LOCAL REG. 8/4/55
REGISTRAR'S SIGNATURE: John H. Posey
24. FUNERAL DIRECTOR ADDRESS: W.W. CHAMBERS Co - RIVERDALE, MD.

RELEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07686

7682

CERTIFICATE OF DEATH

Reg. Dist. No. 100

Items 9,13,14 Film 6187 9-29-55 et Item 14, Film 6187 10-4-55 et

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata
LENGTH OF STAY (in this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 166 Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Charles
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanjemoy X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) IRENE (Middle) (Last) JACKSON

4. DATE OF DEATH: (Month) 8 (Day) 22 (Year) 19 55

5. SEX: F | 6. COLOR OR RACE: Col | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W. | 8. DATE OF BIRTH: 9/17 | 9. AGE last birthday 70 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Md | 12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Noble Dorsey | 14. MOTHER'S MAIDEN NAME: Unknown Lucy Simpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

IMMEDIATE CAUSE (A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8-18-55

ANTECEDENT CAUSE (S) DUE TO (B) Hypertension — 4 yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-18, 19 55, to 8-22, 19 55, that I last saw the deceased alive on 8-22-55, 19 55, and that death occurred at 6 P M, from the causes and on the date stated above.

SIGNATURE C. Fidelen M. D. ADDRESS La Plata Md DATE SIGNED 8-24-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8/25/55 | NAME OF CEMETERY OR CREMATORY St Charles | LOCATION (City, town, or county) (State) La Plata/No Hend Md

DATE REC'D BY LOCAL REGISTRAR 8/25/55 | REGISTRAR'S SIGNATURE Julia A Posey | 24. FUNERAL DIRECTOR Henry C. Cofer | ADDRESS Mason Funeral Home

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07687

7683

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS 66 Physicians Memorial

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Chas
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel Alton X 1
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) Marian (Middle) M. (Last) Jackson

4. DATE OF DEATH: (Month) Aug (Day) 25 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: Oct 31 1882

9. AGE last birthday 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George C Oliver

14. MOTHER'S MAIDEN NAME: Mary Goodrich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs Hilda Chesildine Washington D.C.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442 X

IMMEDIATE CAUSE (A) Acute Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Chronic Glomerulonephritis — 2 yrs.

DUE TO (C) Generalized Arteriosclerosis & Nephrosclerosis — 5 yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Rheumatoid Arthritis — 10 yrs.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1946, to Aug. 25, 1955, that I last saw the deceased alive on Aug. 25, 1955, and that death occurred at 9:35 P.M. EST, from the causes and on the date stated above.

SIGNATURE Harvan Barber M.D. M.D. ADDRESS La Plata, Md DATE SIGNED 8-25-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Aug 29 1955 — NAME OF CEMETERY OR CREMATORY Trinity Cemetery — LOCATION (City, town, or county) Newport (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 9/1/55 — REGISTRAR'S SIGNATURE Julia H Posey

24. FUNERAL DIRECTOR Hewitt & Ryon — ADDRESS Waldorf, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07688

7684 CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X La Plata
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X
STREET ADDRESS (If rural give location) Tompkinsville Rural

3. NAME OF DECEASED (First) Theophilus (Middle) Zachary (Last) Mattingly
4. DATE OF DEATH (Month) Aug (Day) 29 (Year) 1953

5. SEX: M
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED: Married
8. DATE OF BIRTH: Sept 10 1886
9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Mln.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Charles Co Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry B Mattingly
14. MOTHER'S MAIDEN NAME: Molly Brooke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-34-4446
17. INFORMANT & ADDRESS: Margaret T. Mattingly

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 min

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Arteriosclerosis, generalized — 4 years
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from June, 1950 to Aug 29, 1953, that I last saw the deceased alive on 29 Aug, 1953, and that death occurred at 8:30 P M, from the causes and on the date stated above.
SIGNATURE C A Woodall MD M. D. ADDRESS La Plata Md. DATE SIGNED 1 Sept 53

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Sept 1st 53
NAME OF CEMETERY OR CREMATORY: Holy Ghost
LOCATION (City, town, or county) (State): Issue Md

DATE REC'D BY LOCAL REGISTRAR: 9/1/53
REGISTRAR'S SIGNATURE: Julia A Posey
24. FUNERAL DIRECTOR: Quehost Funeral Home ADDRESS La Plata

VS. A15—10-53

07689

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7685 **CERTIFICATE OF DEATH** Reg. Dist. No. 106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN X Indian Head
LENGTH OF STAY (in this place) 5yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Route 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head X
STREET ADDRESS (If rural, give location) X

3. NAME OF DECEASED: (Type or Print) (First) Finnie (Middle) Harrison (Last) McCoy

4. DATE OF DEATH: (Month) August (Day) 3 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug 30 1878

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Fireman

10b. KIND OF BUSINESS OR INDUSTRY: US Govt

11. BIRTHPLACE (State or foreign country): Pikeville, Ky.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James McCoy

14. MOTHER'S MAIDEN NAME: Melissa Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: 406-09-6257

17. INFORMANT & ADDRESS: U.S. Finnie McCoy Indian Head Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

443X
Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 10 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO (b) Hypertensive Heart Disease — 5yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY — M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 19..55.., to Aug 3 19..55.., that I last saw the deceased alive on Aug 1 19..55.., and that death occurred at 7:30 A.m., from the causes and on the date stated above.

SIGNATURE Martha Susan (DEGREE OR TITLE) M.D. ADDRESS Indian Head, Md DATE SIGNED 8-3-55

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 8-6-55 — NAME OF CEMETERY OR CREMATORY St. Lincoln — LOCATION (City, town, or county) (State) Prince George Co. Md

DATE REC'D BY LOCAL REG. Aug 5-55 — REGISTRAR'S SIGNATURE M. L. Monroe — **24. FUNERAL DIRECTOR** Hunter & Ryon Waldorf, Md — ADDRESS

Mr. Odey Price

07690

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7686

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

20852793 60

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LaPlata
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Neale

4. DATE OF DEATH: (Month) Aug (Day) 13 (Year) 1955

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): S

8. DATE OF BIRTH: Aug 13, 1955

9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 2 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James E. Neale

14. MOTHER'S MAIDEN NAME: Wabanaka Veronica Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT & ADDRESS: James Neale, LaPlata, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.5 IMMEDIATE CAUSE (A) Respiratory Failure

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Prematurity

(C)

INTERVAL BETWEEN ONSET AND DEATH 8-13-55

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-12, 1955 to 8-13, 1955, that I last saw the deceased alive on 8-13 1955, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

SIGNATURE E. Neale M. D. ADDRESS LaPlata Md DATE SIGNED 8-14-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 8/14/55

NAME OF CEMETERY OR CREMATORY Sacred Heart

LOCATION (City, town, or county) (State) LaPlata Md

DATE REC'D BY LOCAL REGISTRAR 8/14/55

REGISTRAR'S SIGNATURE Julia H Coney

24. FUNERAL DIRECTOR ADDRESS James Neale, LaPlata, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07691

7687 CERTIFICATE OF DEATH Reg. Dist. No. 106

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ironsides
LENGTH OF STAY (in this place) 82 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ironsides X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) I. (Last) Posey

4. DATE OF DEATH: (Month) 8-17-55 (Day) (Year) 19

5. SEX: F. | 6. COLOR OR RACE: N. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow | 8. DATE OF BIRTH: 7-22-1873 | 9. AGE last birthday 82 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never (if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: None | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Joseph Montgomery

14. MOTHER'S MAIDEN NAME: Jane Otten

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: (Daughter) Eva Costes

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE 447X	(A) Hypertension	4-Yrs
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Arteriosclerosis	Indefinite
	DUE TO (C) Senility	Indefinite
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1-53, 19..., to 8-17-55, 19..., that I last saw the deceased alive on 8-17-55, 19..., and that death occurred at 7:15PM, from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Indian Head Md DATE SIGNED 8-18-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8/21/55 | NAME OF CEMETERY OR CREMATORY Mt. Hope | LOCATION (City, town, or county) (State) Dorchester Co. Md.

DATE REC'D BY LOCAL REGISTRAR 8/15/55 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR Montgomery Bros. | ADDRESS Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Charles			Charles
Ironsides	82 Years	Ironsides	
Mary	I. Posey		8-17-55
F. N.	Widow	7-22-1873	82
Housewife	None	Maryland	US
Joseph Montgomery		Jane Otten	
No	None	(Designer) Eva Coates	
	Hypertension		4-Yrs
	Arteriosclerosis		Indefinite
	Senility		Indefinite

X

8-17-55 8-1-53 8-17-55

7:15P

Indian Head Md 8-18-55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07692

7683

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 66 Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata X
STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED: (Type or Print) (First) Andrew (Middle) Carroll (Last) Simpson

4. DATE OF DEATH: (Month) August (Day) 1o (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: July 14, 1955

9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days 27 IF UNDER 24 HRS. Hours Mln.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10B. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Carroll Simpson

14. MOTHER'S MAIDEN NAME: Mary Fay Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Carroll Simpson, La Plata, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

760.5 IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Prematurity — 4 weeks

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 14, 1955, to Aug. 10, 1955, that I last saw the deceased alive on Aug. 10, 1955, and that death occurred at 6:50P M, from the causes and on the date stated above.

SIGNATURE John H. Griffin M. D. ADDRESS Hughesville, Md. DATE SIGNED Aug. 10, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Aug. 11, 1955 — NAME OF CEMETERY OR CREMATORY St. Marys — LOCATION (City, town, or county) (State) Bryantown, Md.

DATE REC'D BY LOCAL REGISTRAR 8/12/55 — REGISTRAR'S SIGNATURE Julia H. Casey

24. FUNERAL DIRECTOR Huntt & Ryon — ADDRESS Waldorf, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

20075244 2281

07693

MARYLAND STATE DEPARTMENT OF HEALTH

7689

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head — LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase.
STREET ADDRESS (If rural, give location) 6706 Maple Ave.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Hamilton (Last) Downey
4. DATE OF DEATH: (Month) Aug. (Day) 9 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: 10-26-81
9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical
10b. KIND OF BUSINESS OR INDUSTRY: Commercial
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles E. Downey
14. MOTHER'S MAIDEN NAME: Not known.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-01-0653A
17. INFORMANT AND ADDRESS: Richard Hamilton Downey Indian Head Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
Immediate cause (a) Coronary Occlusion — 24 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — several years
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED
Frank Duncan M. D. Indian Head, Md. 8-9-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 8-11-55
NAME OF CEMETERY OR CREMATORY: George Washington Cemetery
LOCATION (City, town, or county) (State): Hyattsville Md.

DATE REC'D BY LOCAL REG. 8/9/55
REGISTRAR'S SIGNATURE: Odey Price
24. FUNERAL DIRECTOR: Warner E. Symphony — ADDRESS: Silver Spring Md
8434 Eastern